Research

Primer: The Disproportionate Share Hospital (DSH) Program

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The DSH program provides supplementary income to thousands of American hospitals providing care to low income Americans. It is both important and controversial, and worth understanding. This paper will explain the history of DSH, what hospitals are eligible, and how the program is financed; it ends with a discussion of how the program will likely change in the near future and how it can be improved.

THE HISTORY

Before the Disproportionate Share Hospital (DSH) program was introduced, Medicaid used a broad "reasonable costs" standard to provide services and gave states the power to set eligibility and reimbursement standards within the Medicaid program. Then Congress passed the Omnibus Budget and Reconciliation Act of 1981, which established the DSH program in an attempt to move away from the inherently inflationary cost-based reimbursement under the "reasonable costs" regime without hurting hospitals that provided large amounts of uncompensated care to uninsured or underinsured patients. The Medicare DSH adjustment was added as part of the Consolidated Omnibus Budget Reconciliation Act of 1985. States were slow to implement the new program, but implementation increased rapidly in the 1990s when Congressional actions provided incentives to participate in the program, and loopholes that resulted in economic windfalls for the states were recognized.

THE CURRENT DSH PROGRAM

Eligibility

States may create their own eligibility criteria to determine how funds are distributed to hospitals, but they must include funding for some specific classes of facilities: hospitals where Medicaid inpatients account for far more of the patient load than is average for hospitals in that state[1], and hospitals where low income individuals make up 5 percent or more of patients. All hospitals receiving federal DSH funds must have Medicaid utilization rates of at least one percent, and if they offer obstetrics services, they must have at least two OB/Gyns on staff who serve Medicaid beneficiaries.

A hospital's eligibility is determined based on its DSH Patient Percentage. If the DSH Patient Percentage exceeds 15 percent, the hospital is eligible for a DSH payment adjustment based on the size and location of the hospital.

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There is also an alternate special exemption method for calculating the DSH eligibility for large urban hospitals where more than 30 percent of total inpatient care revenue comes from State and local governments in compensation for indigent care (other than Medicare or Medicaid).

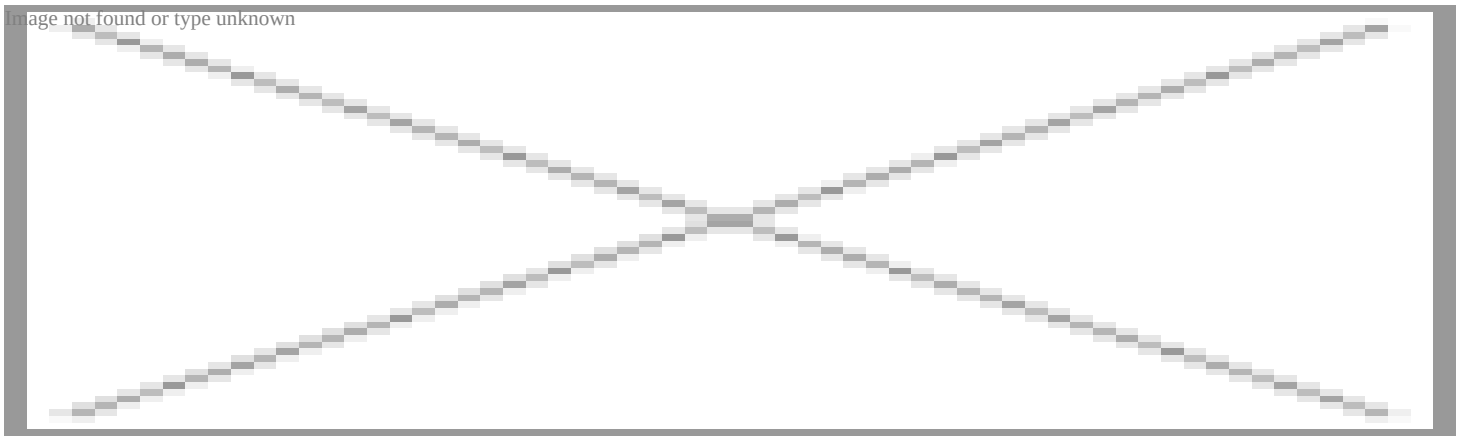
For states to be eligible for federal reimbursement, they must submit an independent, certified audit and an annual report to the Department of Health and Human Services (HHS) describing DSH payments to each hospital. This evidence is necessary because the states' power to determine Medicaid and DSH eligibility creates huge variation in the DSH program allotments and requests from state to state. For example, Low-DSH states are states where FY 2000 DSH expenditure was below 3 percent of total Medicaid spending; there are 16 states considered to be Low-DSH. Six of the High-DSH states receive nearly one half of all DSH funds – those states are New York, California, Louisiana, New Jersey, and Pennsylvania. And in FY2007, Oregon made DSH payments to only nine hospitals (out of 58 hospitals in the state), while New Jersey made DSH payments to every hospital in the state (over 110). These variations make DSH expenditures potentially difficult to predict, and makes the strict DSH state allotments necessary for budgetary reasons.

DSH Allotments By State

Financing

The DSH program is intended to reimburse hospitals for the costs of Medicaid or underinsured patients who leave providers uncompensated for some portion of their care. It applies to acute care hospitals as well as psychiatric facilities. The DSH program now provides the largest source of funds for uncompensated care to these health care facilities.

DSH is a federal-state partnership, much like the Medicaid program it works alongside. The federal government pays states to distribute payments to hospitals to reimburse them for uncompensated care provided to uninsured individuals and to account for low Medicaid reimbursement rates. The federal government reimburses sates for DSH at standard match known as a Federal Medical Assistance Percentage, or FMAP rates. Under FMAP, the Federal government would pay:



This match rate is, however, limited to between 50 and 83 percent. [2]

Though DSH receives a matching rate like the Medicaid program, funding is capped at state and federal levels. DSH payments to a state are capped at either the state's DSH allotment for the previous year or 12 percent of

the state's total Medicaid payments for the year, whichever is greater. Those Medicaid payments are traditionally determined by FMAP plus the state's Medicaid outlays for the program; of note, Hawaii and Tennessee have special statutory arrangements to determine their DSH allotments.

The annual Federal DSH allotment also limits Federal Financial Participation (FFP) by limiting the total statewide expenditures and expenditures per individual that are available. Further, FFP is not available for state DSH payments above the hospital's eligible uncompensated care costs which are calculated using Medicaid inpatient and outpatient volume and uninsured care minus payments received. Annually, CMS publishes a preliminary DSH allotment by the start of the fiscal year estimating each state's anticipated reimbursement, and at the end of the year the allotment will be updated when final spending data for the year become available. In FY 2012, for example, the Federal DSH allotment to states was $11.4 billion.

FUTURE OF DSH

The Affordable Care Act (ACA) was intended to reduce (though never to eliminate) the uninsured and under-insured population, thereby reducing the uncompensated care burden on hospitals and the need for DSH payments. With this in mind, the 111th Congress–which passed the ACA–called for significant DSH reductions to kick in not long after the rest of the bill. The ACA scheduled $500 million in DSH reductions in 2014, $600 million in 2016, $1.8 billion in 2017, $5 billion in 2018, $5.6 billion in 2019, and $4 billion in 2020.

The reduction impact will vary by state from 0.49 percent to 7.14 percent of DSH payments. The Secretary of HHS is required to distribute more of the DSH reductions to states with the lowest percentage of uninsured individuals, or states that do not target DSH payments to hospitals with higher volumes of Medicaid patients or uncompensated care. The Secretary must also consider, when deciding who should bear the burden of the reduction, each state's DSH allotment under the budget neutrality calculation used for Medicaid coverage expansion.

Within states, the reductions to hospitals will be based on a calculation of the hospital's percentage of uninsured patients, the volume of Medicaid inpatient states, and the volume of uncompensated care.

In FY 2021 DSH payment rates were scheduled to return to their pre-ACA levels. However, the Middle Class Tax Relief and Job Creation Act of 2012 extended the DSH reductions an additional year until 2022. Later that year, the American Taxpayer Relief Act of 2012 further delayed the reduction another year until 2023.

PROBLEMS WITH THE DSH FORMULA

The DSH formula is problematic because there is evidence that it does not always succeed in achieving its goals. For instance, MedPAC has found that there is no correlation between the amount of DSH money a hospital receives and the amount of uncompensated care it provides. This could be caused by the DSH formula itself, which bases eligibility on *inpatient* care that is provided to individuals who, by definition have some form of insurance (i.e. Medicare or Medicaid). The formula does not capture all uncompensated care that is provided to patients who are totally uninsured. Furthermore, the formula does not account for any outpatient care provided either, which could miss a significant portion of uncompensated care in some settings.

These problems will likely be compounded by the ACA's Medicaid expansion in many states, in conjunction with the other mandates of the law that will contribute to the migration of millions of people into Medicaid. As

Medicaid eligibility increases, it is likely we will also see at least some increase in DSH eligibility among hospitals in states that implement the expansion.

These quirks in the formula, exacerbated by the Medicaid expansion are problematic because they demonstrate that the program is inefficiently targeting populations that are supposedly helped. Hospitals with massive profit margins, such as Johns Hopkins in Baltimore are being granted DSH funds because they are in high-Medicaid neighborhoods, while more rural hospitals providing totally uncompensated or predominantly outpatient care are denied these benefits because the DSH formula is too rough an approximation of actual need.

More concerning even is the trend towards viewing the DSH formula as sacred and applying it to other programs. The 340B program, for example, is an equally well-intentioned program intended to provide drug discounts to hospitals with particularly high levels of uncompensated care. But because the 340B program relies on the DSH formula to determine eligibility, it falls far short of accomplishing its mission.

CONCLUSION

The DSH program was created with the intention to help compensate hospitals for care provided to indigent patients. However admirable the intent in its creation, like many government programs, the DSH program's limitations can be both costly and self-defeating. The good news is there is plenty of room for improvement, where small changes can make big differences.

[1] This DSH participation requirement applies to hospitals where Medicaid inpatient utilization rates are one standard deviation or more above the mean for hospitals in that state.